CBO Examines Cost of Health Policy Changes

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A health reform plan that calls for either subsidies of health insurance premiums or mandates alone would not result in universal coverage, according to an analysis from the Congressional Budget Office.

Lawmakers, however, could achieve near-universal coverage by combining those policies or implementing them with strategies that simplify the enrollment process, the CBO analysts wrote in one of two reports on health care released last month.

The CBO, created by Congress in the 1970s, provides legislators with objective, nonpartisan analyses to assist with economic and budgetary decisions regarding federal programs, according to the agency's Web site.

One option outlined by the CBO would be to enact an enforceable individual mandate accompanied by subsidies for low-income people. Another possible combination would be to have a voluntary health insurance system with significant government subsidies and a system that facilitates enrollment, similar to how seniors are enrolled in Medicare.

In "Key Issues in Analyzing Major Health Insurance Proposals," the CBO analysts provide an overview of the major issues they will consider in analyzing health reform proposals. In a second report, "Budget Options, Volume I: Health Care," they outline 115 specific health policy options and their costs or potential for savings. The options examined range from the establishment of association health plans to the limitation of awards from medical malpractice lawsuits.

The reports address some of the common elements from the major health reform proposals, but do not analyze any particular package. The CBO's projections are being closely watched as members of Congress prepare to consider significant changes to the U.S. health care system.

As part of this effort, the CBO also analyzed some commonly proposed approaches to reduce costs and improve the quality of health care. These include reducing rates of obesity and smoking, expanding the use of preventive medical care, adopting disease management programs, funding comparative effectiveness research, expanding the use of health information technology, and establishing a medical home for health plan enrollees.

While these ideas could improve quality and health, the evidence is unclear about their impact on overall federal spending, the CBO wrote.

For example, in the case of health information technology, as more physicians and hospitals adopt electronic medical records under current law, it becomes less cost effective to offer subsidy payments for adoption.

If a system of subsidies is established in the future, then the government would incur additional costs but might not significantly improve adoption rates over current levels, a phenomenon known as "buying out the base," according to the CBO.

The impact of the medical home on health care spending is also unclear, according to the CBO analysis. The use of a medical home to coordinate care might help reduce costs if the primary care physician who was coordinating care had a financial incentive to limit the use of specialty care. However, the medical home could also result in a greater use of services and therefore increase costs, the CBO wrote. ■

The CBO reports are available online at www.cbo.gov.

Deadline for ICD-10 Transition Is Set for 2013

In less than 5 years, physicians and other health care providers will be required to begin using a new system of code sets to report health care diagnoses and procedures.

Under a final rule published in the Federal Register last month, the Health and Human Services department is replacing the International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) code sets now used with a significantly expanded ICD-10 code sets. Providers and health plans will have until Oct. 1, 2013, to implement the new code sets.

In addition, HHS also issued a final rule adopting new standards for certain electronic health care transactions. The rule requires health care providers to come into compliance with the updated X12 standard, Version 5010, which includes updated standards for claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions. Use of the updated standard is necessary to use the ICD-10 code sets, according to HHS.

Providers and health plans must be in compliance with the updated transaction standard by Jan. 1, 2012.

At press time, the Obama administration was in the process of reviewing and approving all new and pending regulations written under the previous administration, including the ICD-10 rules. However, a spokesman for the Centers for Medicare and Medicaid Services said that until the review is complete, it is not possible to determine which regulations will be affected.

The move to the new code sets was necessary, HHS said, to replace the outdated ICD-9 code sets. The ICD-9-CM contains about 17,000 codes, compared with 155,000 in the ICD-10 code sets.

"These regulations will move the nation toward a more efficient, quality-focused health care system by helping accelerate the widespread adoption of health information technology," Mike Leavitt, HHS Secretary, said in a statement. "The greatly expanded ICD-10 code sets will fully support quality reporting, pay-for-performance, biosurveillance, and other critical activities."

The final rule gives health care providers and plans almost 2 extra years to implement the Version 5010 transaction standard and a full 2 years to switch to ICD-10, compared with the timeline originally proposed last year. HHS officials said they decided to allow extra time for implementation in response to concerns that a short implementation phase would result in high implementation costs and inadequate time for training and testing.

Although physician groups generally welcomed the additional time, they also expressed concern about the administrative burdens and costs that the transition would entail.

Physician groups praised HHS for providing additional time for implementation but said other issues persist.

Officials at the American College of Physicians said they believe the benefits of switching to the ICD-10 code sets in the ambulatory setting do not outweigh the collective costs, said Brett Baker, director of regulatory affairs.

The costs and administrative burdens related to adopting ICD-10 could slow adoption of health information technology and make it more difficult for physicians to engage in quality improvement efforts, said ACP.

ACP is urging HHS to explore alternatives to the implementation plan outlined in the final rule. For example, the department could delay implementation of ICD-10 in the outpatient setting until a certain percentage of physicians adopted interoperable electronic health record systems. Since EHRs would ease the adoption burden for physicians, it makes sense to wait until adoption of health information technology reaches a certain threshold point, Mr. Baker said.

The Medical Group Management Association echoed concerns that physician practices will struggle to implement the new code sets. The association is calling on the federal government to develop some type of implementation assistance program to help physicians, especially those in small practices and rural communities. If the value to the health system is as significant as HHS estimates, government officials should be prepared to invest that savings early on to ensure implementation runs smoothly, said Robert Tennant, who serves as senior policy adviser at MGMA.

HHS also should extend its outreach to the vendor community, Mr. Tennant said, since they will be the ones to provide updates to the practice management software. HHS also needs to work with private health plans to ensure there is no disruption in payments.

For their part, Mr. Tennant advised physician practices to get started by becoming familiar with the requirements and the compliance dates. Next, reach out to vendors of practice management software and find out their plans for updating the software, including the timeline and costs. With that information in hand, practices can formulate a budget for implementation that includes training and testing, he said. ■

Details of 2009 PQRI Measures Now Online

Detailed descriptions of the quality measures and measures groups that can be used as part of the 2009 Medicare Physician Quality Reporting Initiative are now available online.

Officials at the Centers for Medicare and Medicaid Services also have posted an implementation guide for claims-based reporting in 2009 and instructions for reporting using measures groups.

Among the 153 measures eligible for reporting in 2009 are 52 new measures, including elder maltreatment screening and follow-up planning, glucocorticoid management in rheumatoid arthritis, and influenza immunization in pediatric end-stage renal disease. The measures and related guidance documents are available at www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp.

Late last year, CMS officials began listing the names of physicians and other health care professionals who reported on at least 1 of the 74 PQRI measures in 2007 at www.medicare.gov/physician.

In additiona to the listing of physicians, CMS officials included general information about the PQRI program. They noted that physicians might have had good reasons not to report measures and that a failure to report through PQRI does not reflect a lack of commitment to high quality care.

For example, CMS officials wrote that reporting quality data may have been too costly for some physicians or that physicians may have been engaged in other quality improvement reporting activities. ■